

## FORM 5 PROVIDER AGREEMENT INSTRUCTIONS

**THE FORM 5 IS COMPRISED OF THREE PAGES. READ THESE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM 5 ACCORDING TO THESE 8 STEPS**

### Form 5: Provider Agreement, pg. 1

Rev. 3/04.

**Leave blank** → Provider Number: - \_\_\_\_\_

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DIVISION ADULT & CHILD HEALTH, DEPARTMENT FOR PUBLIC HEALTH  
FIRST STEPS

**Leave blank**

**PROVIDER AGREEMENT**

THIS PROVIDER AGREEMENT, made and entered into as of the \_\_\_\_\_ day of \_\_\_\_\_  
200 by and between the Commonwealth of Kentucky, Division Adult & Child Services, Dept of Public Health, Kentucky Early Intervention, 275 East Main, Frankfort, Kentucky 40621 hereinafter referred to as ACH, and

\_\_\_\_\_  
(Name of Provider)

\_\_\_\_\_  
(Address, City, State, Zip of Provider)

hereinafter referred to as the Provider.

**Fill in your Name or the Name of your Business & Address**


January, 2003 Version 1.0 Page 3

- Provider Number:**
  - New Providers:** Leave the provider number blank (upper right hand corner of page 1). CBIS will assign you a provider number upon CSHCN approval of your provider agreement.
  - Renewals/Addendums:** Enter the same provider number under which you are currently submitting bills to CBIS.
- Date Contract Entered Into:** Leave month, day, & year blank (page 1). This will be completed by CSHCN upon approval of your contract.
- Name of Provider:** Enter the legal name (your social security number or Federal Tax ID) of the entity requesting to become a First Steps Provider. (An entity can be either an agency or an independent provider.) This is the name under which your contract will be maintained in our records.
- Address of Provider:** Include your complete mailing address.

5. **Provider Signature** (Authorized Signature): You must include an original signature. (Copies and electronic signatures cannot be accepted.) The signature should be of the individual authorized to commit the entity to providing services, adhering to First Steps regulations, policies, and procedures. Include the individual's title and the date signed.

## Form 5: Provider Agreement, pg. 3

Read the full text of the Provider Agreement pages 1 and 2 and sign page 2 as shown below:

PROVIDER	DEPARTMENT FOR PUBLIC HEALTH ADULT AND CHILD SERVICES
BY: 	BY: _____
Authorized Official	Authorized Official
NAME: _____	NAME: Steve Davis, M.D.
TITLE: _____	TITLE: Director
DATE: _____	DATE: _____

**PRINT Name, Title & the Date**  
If contract is with an agency, this should be signed by the individual with the authority to sign a legal document

**Leave blank**

## Form 5: Provider Agreement, pg. 3

Read carefully the full text of the Provider Agreement regarding Violation of Tax & Employment Laws.

\_\_\_\_\_ The contractor **has** violated the provisions of d  
five (5) year period and has revealed such final deter  
determination(s) is attached.

\_\_\_\_\_ The contractor **has not** violated any of the pro  
year period.

**Check the appropriate statement. If the  
first statement is checked, attach the  
statement of findings to the agreement.**

FIRST PARTY:  
DEPARTMENT OF PUBLIC HEALTH  
ADULT AND CHILD HEALTH DIVISION  
Name of Agency

**Print Here**

SECOND PARTY:

**Sign Here**

Name

BY: \_\_\_\_\_

Signature

Date

Version 1.0

Page 5



6. **Violation of Tax and Employment Laws** (page 3 of Form 5: Provider Agreement):  
This form must be fully completed and signed by the same person who is the authorized party that signs the provider agreement. You must check whether you have or have not violated one or more of the referenced statutes. You will sign as the Second Party.

Note: Do not complete the "Approved" or "Examined for Form and Legality" sections on the lower left hand-side. This is for internal use by the Cabinet for Health Services and Finance and Administration Cabinet.

If you have violated one or more of the provisions, you must attach the statement of finding(s) and your written response to the finding(s).

## Form 5: Provider Agreement, pg. 3

The contact person you designate will be responsible for maintaining communication with the First Steps staff.

**Print Information Here**

Contact Person responsible for disseminating all information from communication packet to all involved in Early Intervention Services.

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

E:MAIL ADDRESS: \_\_\_\_\_

All service providers required to have a state license must provide the Commission with a current copy.

**Submit copy(s) of license(s) with this agreement**

January, 2003

Version 1.0

Page 6



7. **Contact Person:** Do not leave this field blank. As a First Steps provider you will receive important information from time to time that must be communicated to personnel who deliver First Steps services and/or are responsible for administrative operations. Because of the number of providers and costs involved, this person agrees to be the central clearinghouse in your entity for all First Steps related information. The contact person assumes responsibility for disseminating First Steps information to appropriate staff in a timely manner. At any time if there is a change in the contact person or address, you must notify CSHCN Provider Relations in writing (e-mail, letter, fax) within 10 working days of the new address. All communications must include your assigned CBIS provider number.
8. **E-Mail Address of Contact Person:** All First Steps provider entities (agencies and independent practitioners) are required to provide a valid E-Mail address. E-mail may be used occasionally to alert providers to important changes that are posted on the web site and to contact the provider regarding specific issues. At any time during the contract period that the e-mail address changes, you must notify CSHCN Provider Relations in writing (e-mail, letter, fax) within 10 working days of the new address. All communications must include your assigned CBIS provider number.

**Original Signature is Required**

**Do Not Fax or Electronically Send Form 5: Provider Agreement**